

QUESTIONS/COMMENTS	RESPONSE
1 If a hospital chooses not to apply for CHIRP by the April 5, 2021 deadline, when would be the next opportunity to apply?	There is only one annual enrollment period for participation in CHIRP. Assuming CHIRP is approved by CMS for another program year, a hospital's next opportunity to apply will be during this time next year.
2 A provider submitted their application already. However, the provider would now like to revise their application to participate in the ACIA component of the program. Can HHSC re-open their application or delete it and let them re-apply?	An application cannot be modified after it's been submitted. Please resubmit the application and HHSC will accept the most recent version received.
3 A facility wants to participate in both UHRIP & ACIA in the CHIRP program. However, they had an unfriendly change of ownership in May 2019, and the previous owners will not give the data to the current owners so that they can supply the ACR data for the ACIA incentive. Based on section §353.1306(c)(3) of the CHIRP rule, what will be required for the facility to submit to be able to participate in the ACIA incentive?	In the interest of having consistency across all providers, HHSC will only be accepting 2019 data for ACR. We cannot calculate the ACIA component of the payment without ACR data. Contracts will not assist us with this task. If he has any portion of data from fiscal year 2019, even if it is less than 12 months, we will accept it.
4 If the facility can provide the contracts for 2019 instead of the data, would that be sufficient? The previous owner has the data from July 2018 to May 2019, and will not provide it to the facility.	We cannot calculate the ACIA component of the payment without ACR data. Contracts will not assist us with this task. If the facility has any portion of data from fiscal year 2019, even if it is less than 12 months, we will accept it.
5 We are still waiting on a TPI# for a provider. Is there a way to apply for the CHIRP without a TPI# or can we have an extension to submit the application until we are assign a TPI#?	No extensions to the application period will be given. HHSC is encouraging all providers to apply to CHIRP, but eligibility for enrollment will be reviewed once the application period closes. Applying to the program does not guarantee a payment.
6 What period should be used for hospitals that opened in December of 2019 or in 2020? Data period requested on the survey is fiscal year 2019 activity.	The data period for the ACR needs to be consistent across all providers. Please enter \$0 if there is no data for the time period requested. Or if there is limited data, or only a few months of data, please enter what is available for that time period.
7 Please provide a clear definition for Commercial Insurance Criteria on the following: Do Indemnity Plans meet the criteria as a Self Insured plan and can be included?	Yes
8 I have outlined Government Plans as Medicare, Medicaid, State Children's Health Insurance Program, TRICARE, Veterans Health Administration, CHAPUS, and Indian Health Services program. Do healthcare exchanges (marketplace plans) meet the criteria as a Government plan or can they be classified as Self Insured?	No, insurance obtained on the marketplace are considered commercial. Only plans in the categories above are considered governmental.
9 Do the Federal Employee Health Benefits Programs offered count as a Governmental plan, example (BCBS, NALCHBP, GEHA ect..) or as a Group Health Plan?	Those are group health plans.

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<p>10 Please clarify "other payors" from this statement in the application:</p> <p>Do not include information for services paid by a combination of commercial insurance and <i>other payors</i> (Medicaid, Medicare, VA, Champus, etc.).</p> <p>Does this mean to exclude any claim that has any secondary payor or just a governmental payor?</p>	<p>Exclude any claim that has a governmental payor as the secondary payor.</p>
<p>11 My firm represents a hospital that would like to apply for the Comprehensive Hospital Increase Reimbursement Program (CHIRP). The hospital will not be opening up till later this year. Is there is an option to apply to the CHIRP program after October 2021 and still be eligible to report data for this year?</p>	<p>The only application period for participation in CHIRP state fiscal year 2022 will close on April 5th. If the hospital will not be open until October, they will not be able to apply.</p>
<p>12 If a hospital is enrolled in Medicaid by October 2022, can they participate for the following fiscal year, 2023?</p>	<p>Yes, a hospital can apply to participate for the following fiscal year, pending the program is approved by CMS for another year, and enrollment criteria and eligibility do not change.</p>
<p>13 May we have an extension to complete the CHIRP application?</p>	<p>No extensions to the application period will be given. The application period closes on April 5th at 5 p.m.</p>
<p>14 We have noted claims that have charges not covered by the commercial payor and yet have a small payment from the commercial payor for the covered charges. In those instances, we have assumed those claims should be excluded from the data provided, for we do not have a way to separate the covered versus non-covered charges. This would seem to accord with the instructions, which state "all information is for services covered by commercial insurance only."</p> <p>Is this treatment permissible? Including the small payments but gross charges on these accounts dilutes the commercial payment to charge ratio and does not seem to accurately reflect the average commercial rate.</p>	<p>If this question is asking to exclude non-covered services by commercial insurance, then that would fall within the guidelines of the instructions.</p>
<p>15 Are we allowed to adjust the commercial payments for payment increases enacted from 2019 to 2021/22? For example, there are commercial payment increases enacted each year, and accordingly, the 2019 data is not representative of the actual ACR gap that will be present in 21/22. Similarly, we may have hospitals that experience changes in the average rates because high acuity units were opened after 2019.</p> <p>If this is allowed, how much did Medicaid payment rates increase from 2019 to 2021/22? In determining this gap, we expect HHSC would inflate the Medicaid payments just as the commercial payments.</p>	<p>No. Data should not be adjusted or inflated. HHSC will only be accepting 2019 data for ACR and it needs to be consistent across all providers.</p>

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<p>16 When pulling data for the ACR request for the ACIA part of CHIRP, are we to exclude those plans where the payments come directly from the Federal or State government? Like Traditional Medicare & Traditional Medicaid? Where can we find the written policy on what the State considers a government health insurance?</p> <p>For instance, Medicare Managed Care, it is a private insurance plan that is a contract between the hospital and commercial insurance company, not a public insurance plan like traditional Medicare that is a direct contract between the federal government and the facility, the claims are paid by the commercial insurance company which makes a profit on the plan, is that considered governmental?</p>	<p>Governmental plans that should be excluded for purposes of the Average Commercial Reimbursement data include: Medicaid, Medicare, the State Children's Health Insurance Program (SCHIP), the Department of Defense TRICARE and TRICARE for Life programs (DOD TRICARE), the Veterans Health Administration (VHA) program, and the Indian Health Service (IHS) program. If the source of a payment is governmental, it should not be reported.</p>
<p>17 We have heard feedback that there is some uncertainty related to questions #13 and #14. How are these questions intended to be answered for funding entities that operate an LPPF? For example, for a hospital district which submits IGT on their own behalf, but also operates an LPPF which funds for private hospitals, should they be answering this question for themselves only, or for all providers which will be funded via the LPPF as well? I think the terminology of "IGT supported through public funds" is causing some uncertainty.</p>	<p>Questions 13 and 14 are required by the CHIRP rule in subsection §353.1306(e)(b):</p> <p>(e) Eligibility. HHSC determines eligibility for rate increases by SDA and class of hospital.</p> <p>(1) Service delivery area. Only hospitals in an SDA that includes at least one sponsoring governmental entity are eligible for a rate increase.</p> <p>(2) Class of hospital. HHSC will identify the class or classes of hospital within each SDA described in paragraph (1) of this subsection to be eligible for a rate increase. HHSC will consider the following factors when identifying the class or classes of hospital eligible for a rate increase and the percent increase applicable to each class:</p> <p>(A) whether a class of hospital contributes more or less significantly to the goals and objectives in HHSC's managed care quality strategy, as required in 42 C.F.R. §438.340, relative to other classes;</p> <p>(B) which class or classes of hospital the sponsoring governmental entity wishes to support through IGTs of public funds, as indicated on the application described in subsection (c) of this section;</p> <p>The CHIRP application is intended to collect information about an individual hospital. Thus, please complete questions 13 and 14 from the perspective of the hospital.</p>
<p>18 Can I get a copy of the application in PDF form?</p>	<p>Yes. A PDF is available on the HHSC Provider Finance Communications page. Here is a link to the PDF: https://rad.hhs.texas.gov/sites/rad/files/documents/pfc/2021/03-15-2021-chirp-app.pdf</p>
<p>19 The application requests individual provider data for participating in the ACIA Component; however I don't see the applicable time period for the data – do you know the related time period for this information?</p>	<p>Commercial insurance data should include inpatient discharges and outpatient services provided during the hospital fiscal year ending in calendar year 2019.</p>

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<p>20 Can providers include exchange plans within the ACR data submission for commercial or should this data exclude exchange plans?</p>	<p>If by "exchange plans" it means an insurance plan that was purchased using a health insurance exchange, then inclusion of the data depends on if the insurance plan is a commercial plan, not whether it was purchased using a health insurance exchange. Here is the general criteria for commercial insurance:</p> <ul style="list-style-type: none"> -Commercial insurance should include data from group health plans, self-insured plans, and managed care organizations (non-governmental plans). - Commercial insurance data should include inpatient discharges and outpatient services provided during the hospital fiscal year ending in calendar year 2019. -All information is for services covered by commercial insurance only. -Do not include information for services paid by a combination of commercial insurance and other payors (Medicaid, Medicare, VA, Champus, etc.). -Exclude claims where payment was \$0 or was totally denied. -Include only payments and charges for encounters that have been fully adjudicated; exclude payments and charges for encounters that are going through the adjudication process. -Include payments and charges associated with co-pays and deductibles if they are combined with commercial insurance, but not for persons who are wholly self-pay. -Commercial insurance data should not include settlements such as motor vehicle or workers compensation, government plans (Medicare, Medicaid, etc.), self-pay/uninsured, or international coverage linked to other countries or provider to provider contracts.
<p>21 In a previous email, you clarified that the 'hospital fiscal year' ending in 2019 should be the cost reporting fiscal year ending in 2019. It has come to our attention that some providers we are working with have a cost reporting fiscal year ending in 2019 with 13 months due to a Change of Ownership (CHOW).</p> <p>Please confirm whether you are requesting a 12-month set of data that ends as of the cost reporting fiscal year ending in 2019.</p> <p>In this specific case, the provider has a FYE12/31/2019 cost reporting fiscal year end, but its FYE12/31/2019 cost reporting period was the 13 months from 12/1/2018 thru 12/31/2019 due to a CHOW effective 12/1/2018. Do you want the provider to submit data on the CHIRP application for discharges/services provided during the 12 months 1/1/2019 thru 12/31/2019? Or is there another period from which you wish the data to be pulled?</p>	<p>After review of our best practices and policy regarding this unique situation HHSC can report that this provider may use the 13 month cost report period, however, that is as long as the same 13 month period for both commercial payments and charges is also being reported.</p>
<p>22 How should we utilize the CHIRP modeling spreadsheets published on the Provider Finance Communications webpage? Should we use the numbers as an estimation as to what we could earn for these programs?</p>	<p>These spreadsheets are for illustration purposes only and will change based upon actual enrollments. This is a preliminary estimate based upon the data we have on hand of what a provider might get under this program.</p>
<p>23 In the CHIRP modeling, if "No ACIA Payment" is shown for a provider, does that mean they cannot participate in ACIA and the provider should not apply? Or should the provider apply for ACIA and HHSC will determine if the provider qualifies to participate in ACIA after the application process?</p>	<p>A provider SHOULD apply for any component for which they would like to participate. HHSC will communicate estimated program revenues after the application period closes, which will include a similar breakdown of UHRIP vs ACIA payments based on fully-funded IGT. Because the modeling is only illustrative, and we lacked data for a number of providers for the ACIA component, we highly recommend providers submit new data through the formal application process.</p>

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<p>24 Are there any plans revise the CHIRP modeling with updated ACR data, and if so when will that be released?</p>	<p>We are not planning on releasing a revised CHIRP model, but once the application period closes we will communicate estimated program revenues to all providers who enrolled, with payments by provider divided into UHRIP and ACIA based on fully-funded intergovernmental transfers. Our plan is to send that information to providers on April 20th.</p>
<p>25 One of our clients did not participate in UHRIP this year, so they were not included in the model for the CHIRP reimbursement. Would it be possible to have them included in the model or for HHSC to calculate the estimated benefit of enrolling in CHIRP? Additionally, has their been any modeling in terms of how much IGT would be required from each provider?</p>	<p>We are not planning on releasing a revised CHIRP model, but once the application period closes we will communicate suggested IGT responsibilities and estimated program revenues to all providers who enrolled, with payments by provider divided into UHRIP and ACIA based on fully-funded intergovernmental transfers. Our plan is to send that information to providers on April 20th. We do not have any modeling on how much IGT would be required for each provider currently.</p>
<p>26 On the modeling put out for RURAL impact of CHIRP for the Hidalgo MRSA, why is the UHRIP projection showing \$0 benefit for both RURAL facilities in that MRSA?</p> <p>They are the only two in the entire CHIRP RURAL IMPACT modeling that have a \$0 UHRIP impact, is that right? If so, could someone help explain why?</p>	<p>Yes, the rural Hidalgo class/SDA combination only has 2 hospitals, and they are estimated to receive \$0 for the UHRIP component. The UHRIP component is determined by the aggregate Medicare UPL gap for all hospitals in the SDA and class. Both hospitals in rural Hidalgo have negative Medicare UPL gaps, so the aggregate Medicare UPL gap is negative, resulting in a 0% UHRIP rate increase for rural Hidalgo. They are the only rural hospitals showing a 0% UHRIP rate in the model, because they are the only rural SDA with a negative aggregate Medicare UPL gap.</p>
<p>27 What is the definition of sponsoring governmental entity?</p>	<p>The definition for sponsoring governmental entity is found in TAC §353.1301 General Provisions and reads as follows:</p> <p>Sponsoring governmental entity--A state or non-state governmental entity that agrees to transfer to HHSC some or all of the non-federal share of program expenditures under this subchapter.</p> <p>This TAC is referenced in both the UHRIP rule (TAC § 353.1305) and the CHIRP rule (§ 353.1306) in subsection (b) definitions:</p> <p>(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this and other sections of this subchapter may be defined in §353.1301 of this subchapter (relating to General Provisions).</p>

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28	<p>On the CHIRP application, does the definition of commercial insurance exclude a payor like superior medicaid and/or humana medicare?</p> <p>Obviously the beneficiary is qualifying as Medicare or Medicaid, but our contract is with a commercial entity and subject to negotiated rates.</p>	<p>The instructions of the application provide the following general criteria for commercial insurance:</p> <ul style="list-style-type: none"> -Commercial insurance should include data from group health plans, self-insured plans, and managed care organizations (non-governmental plans). - Commercial insurance data should include inpatient discharges and outpatient services provided during the hospital fiscal year ending in calendar year 2019. -All information is for services covered by commercial insurance only. -Do not include information for services paid by a combination of commercial insurance and other payors (Medicaid, Medicare, VA, Champus, etc.). -Exclude claims where payment was \$0 or was totally denied. -Include only payments and charges for encounters that have been fully adjudicated; exclude payments and charges for encounters that are going through the adjudication process. -Include payments and charges associated with co-pays and deductibles if they are combined with commercial insurance, but not for persons who are wholly self-pay. -Commercial insurance data should not include settlements such as motor vehicle or workers compensation, government plans (Medicare, Medicaid, etc.), self-pay/uninsured, or international coverage linked to other countries or provider to provider contracts. <p>Governmental plans that should be excluded for purposes of the Average Commercial Reimbursement data include: Medicaid, Medicare, the State Children's Health Insurance Program (SCHIP), the Department of Defense TRICARE and TRICARE for Life programs (DOD TRICARE), the Veterans Health Administration (VHA) program, and the Indian Health Service (IHS) program. If the source of a payment is governmental, it should not be reported.</p>